

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/11/2011	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of complaint numbers IN00086393 and IN00086955.</p> <p>This visit was in conjunction with the Post Survey Revisit [PSR] to the Investigation of Complaint Number IN00085599 completed on 2/8/11</p> <p>This visit was in conjunction with the PSR to the Recertification and State Licensure Survey and Investigation of Complaint Number IN00084479 completed on 1/7/11.</p> <p>Complaint number IN00086393 substantiated, no deficiencies related to the allegations are cited.</p> <p>Complaint number IN00086955 unsubstantiated, due to the lack of evidence.</p> <p>Survey dates: March 8, 9, 10, and 11, 2011</p> <p>Facility number: 000220 Provider number: 155327 AIM number: 100267650</p> <p>Survey team: Marcy Smith RN TC (March 8, 10, & 11, 2011) Rhonda Stout RN Leia Alley RN C. Diane Dierks RN (March 9 & 10, 2011)</p> <p>Census bed type: SNF: 23 SNF/NF: 132 Total: 155</p> <p>Census payor type: Medicare: 25 Medicaid: 104</p>			F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155327		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/11/2011	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>Continued From page 1</p> <p>Other: 26 Total: 155</p> <p>Sample: 4</p> <p>University Heights Health and Living Community was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint Number IN00086393 and the Investigation of Complaint Number IN00086955.</p> <p>Quality review completed 3-15-11 Cathy Emswiller RN</p>			F 000			